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SHALL WE TELL WOMEN WITH UTERINE CANCER THE NATURE OF THEIR DISEASE?

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., England.

Professor Clinical Gynecology in Bishop's College, Montreal.

No more unpleasant task perhaps ever falls to the lot of the tender-hearted physician, and I think the majority of physicians are tender-hearted, than to have to tell a patient that she is suffering from malignant disease. Some deliberately shirk this unpleasant duty on principle, believing that we are not called upon to tell her the truth in these circumstances; while others avoid it from expediency because they dislike to cause pain, or because they think that it pays better to say something pleasant which will cheer up the disconsolate one for the time and leave a temporary agreeable impression on her mind. In the course of a newspaper interview with a great London surgeon, whose name is known all over the world, while speaking of tact as an element of success, he says that the successful physician will not tell a woman that she is suffering from cancer; and one of our greatest Canadian physicians evidently holds the same views, as in consultation over their cases he invariably tells the patient that they will be better soon. As some of these patients were dead two or three weeks later his prognosis was correct in a sense, but not in the one in which the patient would be supposed to take it. The view taken by these two great men, and by many others in the profession, is equally held by a great many of the laity, as seems certain by the number of people who have asked me to tell them

truly what was the matter with their sick friend, but on no account to let the sick one herself know the nature of her malady. Not only do the friends almost invariably take this course, but, strange to say, I have known the patient herself beg that I would not tell her the truth.

Notwithstanding all this, I venture to differ from these doctors, from the patients and their friends, and I wish to enter a firm protest against any other course being adopted than to tell the truth every time; and I think I can show that this is our duty for many reasons. For those (and I hope they are few) who require any other argument than duty, I think that I can prove that it does not pay to deceive a patient even under the mistaken idea that good may come of it.

I am not saying anything about telling the friends what is the matter; for when they have brought me a patient and mysteriously called me to one side to whisper that I could tell them, but not to tell the patient, I have often said to them, "the patient is the only one who has any right to know; what is the matter with her and what she tells me are alike profound secrets; I will tell her and she can tell you if she likes; but I will not tell any one else."

Is it right to tell the truth? At first sight I will admit that it appears more humane not to tell a woman that she has cancer of the womb, but in reality this course is most cruel; for, in each of the three stages into which I will divide the progress of the disease, the woman has an immense stake at risk; she has everything to lose and nothing to gain by being kept in ignorance of her actual condition, and she has a right to know it whether she wants to or not, from the moment the physician knows it himself. In the first stage of cancer of the womb the disease is absolutely local; that is to say it occupies a small spot on the angle of a laceration or is limited to the endometrium. During this stage the disease is positively and entirely curable by the removal of the womb. Vaginal hysterectomy for cancer in this stage by a good operator has at the present time a death rate of two or three per cent. at the very most. Alas, it is bad enough to think that so few cases are even diagnosed at this stage, without wishing that the few which are diagnosed

should be deceived into a fool's paradise, while their physician, whom they trust to save them when they could be saved, quietly stands by and with the friends becomes a conspirator to hide their danger from them, until it is too late to escape it. How can she hold out her hand for help if she does not know that she is in danger. I for one decline to place such a responsibility upon my conscience or to become a plotter against her life, as I would be if I knowingly and willfully concealed from her the one fact that she had cancer of the womb, and the other that vaginal hysterectomy would save her. I shall never forget the remorse of a medical friend who brought me a patient with a large cancer of the uterus with the broad ligaments infiltrated with the disease which he had been treating with caustics for six months, and which was then too far advanced to permit of hysterectomy; looking me straight in the eyes he asked me whether, if he had brought her when he first discovered it, I could have saved her, and I was obliged to answer that I believed I could have done so. He only replied, "I will never forgive myself," and from the tone in which he said it I believed him. And yet he only lost her life through unintentional ignorance of her true condition and not through willful deceit, and he was not therefore anything like so much to blame.

In what I call the second stage the cervix is invaded, the broad ligaments are full of cancerous tissue and the lymphatics are infiltrated with it. The patient is alternately being drained of her life blood by irregular hemorrhages, which she attributes to the change of life, and poisoned by the absorption of decomposing and gangrenous material, which keep her in a burning fever. Her presence, moreover, is made loathsome to her friends by reason of the foul smelling discharge. And yet she does not know that she is a hopeless case of cancer of the womb. Why tell her? Because we can prolong her life, diminish her suffering, and not only thus make her life endurable to herself but render her unoffensive to her family by a thorough use of the curette and cautery. Under an anesthetic we can do all this without any danger or causing any pain, and in a few days she will feel so well that she almost doubts the accuracy of the diagnosis which she has to

thank for her improved condition. I have had, unfortunately, too many of these cases and too few of those in the first stage, but I have had the pleasure of seeing apparently dying woman almost at once become comparatively well. In a few cases I have curetted them a second time at the end of three months more, but as a rule the one curetting has sufficed, and they have died peacefully and painlessly from cancer of the liver from six to nine months later, surrounded by their friends to whom they were no longer an object of disgust. Now, how can they avail themselves of this merciful treatment unless they know the necessity for it ? It is more than we can expect, and certainly more than we often find, a women willing to submit to an operation without knowing the nature of the operation and why it is to be done. If their condition is made known to them they readily consent to have it performed.

In the third stage, where the whole pelvis is filled with a cancerous mass and the bladder and rectum involved, and nothing is to be done except to make death painless, what should be our answer to the woman who asks us what is the nature of her disease, and whether we can cure her. I have had such patients ask me if they could be quite cured in a month, when as events turned out they were fated to be dead and buried in less than that time. Shall we follow the golden rule and do to this poor woman as we would be done by if our positions were reversed ? And would we not wish to know the truth so that we might prepare for death ?

At the beginning of this article I said that duty should be our first consideration, and I hope I have shown that it is our duty in this case, as in all cases, to tell the honest truth. But even from the infinitely lower standpoint of expediency, I hope to show that it pays to tell the truth.

When we hear a friend lying from kindness or expediency, does our opinion of that friend go up or down ? When we have heard him telling a woman with cancer that she will be all right soon, and telling us five minutes later outside the house that he believes she will be dead in a week, and when we have heard him saying the same two opposite things in twenty other cases, will our faith in his word be as

implicit as it would be if we had heard him on every occasion telling the truth, the whole truth, and nothing but the truth? If we weakly comply with the request of the friends and lie to a patient, what will these same friends think of our truthfulness when it is their turn to consult us? Even if we told them the truth, would they believe us? Certainly not, if they knew that we had lied to others in the same circumstances.

We see the effect of this mistaken policy almost every day in patients who have been under several doctors. When we go to examine them they ask us if we will hurt them; if we say "no," they exclaim, "I know you will." If we are going to hurt them it is better to tell them so before hand, and they will bear it quite bravely. It is only after the second or third visit that we will succeed in winning their confidence by telling them the truth every time; and then when we pick up the speculum they no longer jump up saying, "Is that a knife you have in your hand?" By showing them each instrument and explaining what we are going to do, they will no longer fea or doubt us. And this is how it pays to tell the truth; little by little you will build up a circle of friends who will tell their friends that they can depend upon what Dr. so-and-so tells them, and the staunchest friend of all will be the poor dying woman whom you have given a chance to prepare for death. Next to her will be the woman who has been curetted and made comfortable and endurable to her friends; and last but not least the woman will thank you for the truthfulness to which she owes her life, and by which she has been saved from a painful and loathsome death.

Not only does the reputation of, and faith in, the individual physician increase in proportion as his word can be trusted implicitly, but the faith of the public in the profession as a whole would be still greater if even in these distressing cases, no matter how good and kind the motive may be, our invariable rule with every one of us would be to leave nothing undone to make an early and accurate diagnosis, and once that has been done, not to lose a single hour in having the proper treatment carried out.

248 BISHOP STREET.

QUARTERLY RETROSPECT.

(Department for Diseases of Throat and Nose.)

UNDER THE CHARGE OF

GEO. T. ROSS, M.D., Laryngologist to the Western Hospital,

Professor of Laryngology and Rhinology, Faculty of Medicine,
University of Bishop's College, Montreal.

Atrophic Rhinitis.—This almost incurable disease was the subject of a very exhaustive discussion at N. Y. Academy of Medicine in March last, when a symposium was given by various American physicians. The etiology of the disease is not yet satisfactorily solved, as is evident when various authors endeavor to support as many theories as were brought forward on the occasion referred to. Bosworth has for the past twenty years maintained that the disease is a development from the purulent rhinitis of childhood, and as far as my own experience goes I have found in many cases, upon strict enquiry, that this theory is well supported by evidence.

The declaration of Jonathan Hutchison, that inherited syphilis was an etiological factor in every case of atrophic rhinitis, was shown by Wright to be ill founded, while it was admitted that, although many cases have a syphilitic basis, yet all of them have not. Gerber's cases were quoted to show that both syphilis and rachitis were frequently important factors.

The importance of recognising functional collapse of the nasal tissues from atrophic rhinitis was shown by Clarence Rice. Some of the points of difference are as follows:—Functional collapse is not often seen before young adult life, when the effects of combined malnutrition begin to be noticeable, while atrophic rhinitis may often be seen in children at the age of ten. Collapse without atrophy is seen in the poorer classes, or at least with people living in bad hygienic state, and true atrophy in people of any class. Anemia and debility seen in collapse is not necessarily seen in atrophic rhinitis. In the simple dry nose of anemia we find a mucous membrane all shades of palor such as we would expect, but smooth, pressed down tightly on the turbinals which retain their contour, while in atrophic rhinitis, if the patient is well

nourished, any color from that of acute coryza to a dirty gray is found. The surface is granular and the turbinals are more or less destroyed by atrophy. There is also abundant mucopus and crusts in atrophic rhinitis, while in functional collapse almost no secretion is present. Authors generally think that vascular collapse very rarely ends in atrophic rhinitis. The diagnosis is important because the collapse is curable by proper means, it being only of temporary character, while the treatment of the atrophic disease is discouraging.

As to treatment of atrophic rhinitis, the two main indications are local cleansing and stimulation. In children little can be done because they will not as a rule submit to treatment. Alkaline solutions are best to use, and they should be used both before and after a spray of peroxide of hydrogen. Oils should be used sparingly. Menthol improves the quality of secretion and lessens the quantity. The solution should be as strong as the patient can endure, beginning with weaker solutions. Formaldehyde is an ideal remedy for this disease—one part to 5000, and weaker or stronger may be sprayed after the saline spray. Borolyptol is a good form of this drug, and can be diluted 10 to 15 times. Ichthyol in the form of Keroline-Ichthyol 2 and 5 per cent. solutions is advocated, and I can testify to its benefit. The antitoxine treatment formerly advocated has been abandoned. As one-fifth of the subjects of this disease are in ill health, some constitutional treatment is essential. Any existing dyscrasia has to be specially regarded. Change of climate to suit any defect in constitution is called for where it can be done. Iron, arsenic, iodine, cod liver oil, is often needed, and even inunction of oils has given good results. Mechanical means, such as tampons, plugs and bougies, are often useful to stimulate the shrunken glands to secretion. Curetting the diseased membrane has been advocated and the various forms of electricity often are useful. Vibratory massage is thought by some to deserve a leading place amongst remedies, but this demands prolonged applications, and most patients cannot devote as much time as is required for good results. In this connection prevention is dwelt upon as being worth everything, and the care of nasal diseases promptly when they

assert themselves, either in childhood or later, is the best means of avoiding this disease.

Hypertrophied Turbinals.—Submucous linear cauterization is advocated by Pierce as superseding all other methods of reducing hypertrophied turbinals. The technique is simple and the advantages claimed are—cheapness of outfit, reliability, simplicity, not terrifying to nervous people, painless under cocaine, does not destroy mucous membrane, reaction slight, and much less than follow electrical cautery.

Death after removing adenoids, due to hæmophilia—This case, related by Dr. R. Sachs (Hamburg) died four days after operation, all means having failed to arrest the bleeding. The operation was done before the family failing was ascertained, the bleeding tendency being easily traceable. The importance of invariably asking before operation if any evidence of hæmophilia has been at any time noticed is emphasized.

Selected Articles.

TREATMENT OF INOPERABLE CANCER.

By WILLIAM B. COLEY, M. D., New York.

It is unnecessary to state here that however great were differences of opinion as to the value of operations upon cancerous tumors a quarter of a century ago, to-day we are practically all agreed that early and complete removal by the knife, while far from ideal in results, still furnishes the best hope of permanent cure of all the methods with which we are acquainted. This, it is needless to say, applies only to operable tumors, and here at once arises a difficulty in what shall we regard as operable and what as inoperable. Certain general rules may be laid down, but the classification of doubtful cases will have to be left to the personal judgment of the surgeon.

I believe that in recent years much harm has been done by surgeons attempting impossible operations, or performing operations upon patients in cases in which it was clearly impossible to remove the entire tumor. Not infrequently

such operative interference greatly increases the rapidity of the growth of the tumor, and moreover the high mortality which often attends these operations has the unfortunate effect of deterring others suffering from cancer from submitting to operation at a time when the chances for permanent cure are great. We have no right to perform an operation that is attended with the gravest risk unless there is some prospect of being able to save the patient or at least prolong or render more comfortable his life. The fact that the patient himself desires the operation and is willing to assume the risk should have no influence in causing us to break sound surgical principles.

In the brief limits of this paper it will be impossible to speak in detail of all the various methods of treatment employed in inoperable cancer. When we consider the well-established fact that cancer is rapidly increasing throughout the world, and that in spite of the vast improvements in results of operative treatment, three-fourths of all cases become inoperable, we see at once the importance of the subject. If we cannot find any means to cure these patients it behooves us to do all in our power to discover the best methods of rendering the remainder of their lives endurable.

Personally I have long believed the solution of this problem of treatment to be so intimately connected with that of the etiology of cancer that there is little hope of accomplishing much with the former until the latter has been determined.

Eight years ago, in a paper before the Academy of Medicine, I expressed my firm belief that cancer was due to an infection from some extraneous micro-organism. It seemed to me then that the clinical and experimental evidence in favor of this theory was even then sufficiently strong to justify one in hoping that scientific proof would soon be forthcoming.

Those of us who had the privilege of listening to the admirable and convincing papers of Drs. Park and Gaylord at the last meeting of the Academy describing the recent experimental researches of San Felice and Plimmer, as well as their own, cannot but feel hopeful that the problem is nearing a solution.

The present paper will permit only of a brief discussion of the treatment of inoperable sarcoma.

THE TREATMENT OF INOPERABLE SARCOMA WITH THE MIXED TOXINS OF ERYSIPELAS AND BACILLUS PRODIGIOSUS.

The results of this method during the past year have

given me no reason to change the conclusions already expressed in earlier papers.

I still find that round-celled sarcoma is much less susceptible to the inhibitory action of the toxins than spindle-celled, and the melanotic is even less affected.

In regard to the method of preparing the toxins and the technique of administration I have nothing new to add. The preparation which I believe to be the best is the mixed unfiltered toxins of erysipelas and bacillus prodigiosus made from cultures grown together in the same bouillon and sterilized by heating to 58° C. In children and persons much reduced in strength it is safer to use the filtered toxins. The preparation is much weaker; the relative strength of the two being about 1 to 10. Toxins to be of value must be made from very virulent cultures, the virulence being kept up by frequently passing the cultures through rabbits. The preparation being bacteriologically sterile, it can be used with perfect safety in a general hospital ward.

Dosage:—The dose depends largely upon the vascularity of the tumor and upon the condition of the patient, and injections when possible should be made directly into the tumor. The initial dose should seldom be more than one half a minim diluted with boiled water, which should be gradually increased until the reaction temperature reaches 102° or 103° F. After the dose has been increased to one minim dilution is unnecessary. When the injections are given subcutaneously remote from the tumor, much larger doses may be borne. Sometimes 12 or 15 minims may be given before the chill is produced.

Aseptic precautions:—Inasmuch as the administration of these as well as other toxins unquestionably increases the liability to infection, if pathogenic germs are present in the vicinity, great caution should be exercised in sterilizing the hypodermic needle as well as the skin. If the tumor be ulcerated or broken down, great care should be taken to keep the parts aseptic. Lack of such precautions has been the cause of death in two fatal cases. In regard to the duration of the treatment, fortunately we are able in most cases to tell within three or four weeks whether or not the toxins are likely to be beneficial. If no improvement is apparent at the end of this time, it is seldom worth while to continue the injections. In most of the successful cases marked improvement has occurred within a week after the first injections. The growth may disappear in one of two ways. If very vascular there may be rapid breaking down and sloughing of the

tumor, while fibrous elements predominate. Absorption without breaking down is the more likely to occur.

If improvement occurs the toxins should be continued until either the tumor has entirely disappeared or until it has become evident that the injections have lost their controlling influence, as evidenced by the further increase in size.

The question of harm resulting from long continued injections is a very important one. That the toxins may be given for very long periods without injury to the patient has already been proved. In one patient with a three times recurrent rapidly growing carcinoma of the breast and axilla the toxins were administered for two and a half years. The doses were moderate and averaged two a week. The tumor disappeared, the patient gained ten pounds in weight and her general health remained good, until at the end of this time there was both a local recurrence and abdominal metastasis, the disease running a very rapid course and causing death in six months.

In another patient with eight times recurrent spindle celled sarcoma of the chest wall, the toxins were administered with occasional intervals for nearly four years. The disease was held in check by small doses. The patient, who was a well known physician, is at present in perfect health, nearly six years from the beginning of the treatment.

In order to properly explain the curative action of streptococcus of erysipelas and its toxins upon sarcoma, I am convinced more than ever that this action can be explained only on the theory that sarcoma is of a micro-parasitic and infectious origin. I will even go further and say that I believe this action of the toxins furnishes additional evidence in support of the infectious origin of sarcoma and carcinoma. In view of the steady accumulation of successful cases, the early attempts to explain the disappearance of these tumors, upon the theory of mistaken diagnosis or spontaneous disappearance, no longer requires serious consideration. It would be clearly unfair to rule out the cases cured withtoxins on the ground of error in diagnosis without including in the same manner the cases cured by operation. Both classes of cases have been submitted to the same standards of diagnosis with one important exception, viz. that the cases treated with toxins have been submitted to far more severe tests. In the majority of these cases the clinical and microscopical diagnosis was confirmed by a number of the best surgeons and pathologists, instead of by a single individual.

After an experience of upwards of eight years with this method of treatment, the question may be fairly asked,

"Has the method any permanent value, and if so, what are its limitations and dangers?" The question can only be answered by giving a careful resumé of the final results in the cases thus far treated.

This I shall attempt to do as in as few words as possible. Before doing this I should like to briefly report a few unpublished cases.

RECENT UNREPORTED CASES OF SARCOMA TREATED WITH TOXINES.

Case 1. *Recurrent Sarcoma of the Tibia: Amputation Advised.*—F. W. F., male, age 27; unmarried; was referred to me on February 12, 1899, by Dr. J. M. Stewart, of Chesley, Ontario. His family history was good and there was no tuberculous or specific history. In July, 1898, a swelling over the tibia of the left leg was noticed. It slowly increased in size, and on November 25, 1898, it was operated upon by Dr. Stewart, who made an incision down to the bone and scraped out as much of the diseased tissue as possible. The portion that was removed was sent to Dr. John Caven, Professor of Pathology at the University of Toronto, who, after a careful examination, pronounced the growth a spindle-cell sarcoma. The wound healed slowly, and a short time afterward the disease returned locally.

Physical examination showed a tumor over the middle and anterior portion of the left tibia about three by four inches in size, projecting above the surrounding tissues to a distance of ½ to ¾ of an inch. Over the central portion there were two small ulcerated areas.

The patient was sent to the New York Cancer Hospital and was put upon the mixed toxins of erysipelas and bacillus prodigiosus. Within two weeks there was decided evidence of improvement, which continued slowly but steadily until the end of three months, when the growth had entirely disappeared. About a week after the injections had been suspended, the patient became suddenly infected with erysipelas in the unhealed portion of the ulcerated area where the tumor had sloughed out. The patient had a very severe attack of erysipelas, and on his recovery returned to his home in Canada. I personally examined him on the first of September in Toronto, and there was absolutely no trace of any return of the disease. I again heard from him in April, 1900, and he stated that he was in perfect health and engaged in his regular occupation as a farmer.

Case 2. *Round-cell sarcoma of the nose and antrum—partial success.*—J. M., age 42, colored; was referred to me by Dr.

Wm. T. Bull, December 29, 1898, with the following history: One year before he noticed a filling up of the right nostril, and was treated for some time by a throat and nose specialist at one of the clinics, for a polypus. September 28th, 1898, he was operated upon at the New York Hospital, and as much of the tumor as possible removed. It grew again very rapidly after the operation, and when I first saw him it had reached the size of half an egg. The cavity of the right nostril was filled, there was marked bulging of the nose and some bulging of the antrum. He had frequent and severe hemorrhages. He was admitted to my service at the New York Cancer Hospital, January 9, 1899, and the toxins were given daily. Injections were made into the tumor and the doses increased to the point of causing three or four severe reactions a week followed by a temperature of 103° to 105°. The tumor diminished very markedly in size, the hemorrhages stopped, and portions of the tumor filling the nasal cavity sloughed out. With a view of increasing chances of success, a few weeks after the beginning of the treatment, I tied the right external carotid artery. The improvement continued until the middle of March, when there was almost no trace of the tumor remaining. The patient was sent home for two weeks; but during this interval the tumor began to increase in size. Although he was readmitted to the hospital and the treatment was resumed, we were never able to entirely control the disease. There was steadily although slow increase in size, until the fall of 1899, when the tumor grew with great rapidity, and the injections were stopped. The increase of growth was far more rapid after the cessation of the treatment, and he died not long afterward in another hospital, from shock and hemorrhage following operation of excision of the carotid arteries.

Case 3. *Recurrent sarcoma of the cheek, following trauma.*—Mrs. L., aged 40 years, was referred to me by Dr. C. M. Thomas of Spokane Falls, March 8th, 1898, with the following history. The patient was in good health until June, 1897, when she received a blow from a fist upon her left cheek. A swelling appeared at once at the site of the injury and never entirely, disappeared. After a few weeks it began to grow slowly, and seemed to be situated between the skin and the mucous membrane. On February 4th, 1898, it had reached the size of half a hen's egg, when it was removed by Dr. Thomas.

The patient thinks it did not again recur until about November, 1898 When I first saw her, March 8th, 1898, physical examination showed a cicatrix extending from the angle of the mouth on left side backward 2¼ inches.

There was a hard tumor ¾ an inch in thickness and about 2 x 3 inches in area. The tumor was firm in consistence, and was situated between the skin and the mucous membrane. The mouth could be opened only ¾ of an inch, and she had not been able to wear her false teeth for several months.

Mixed toxins were begun at once at the New York Cancer Hospital and continued for six weeks, at the end of which time there was entire disappearance of the tumor. On March 3rd, 1899, I performed a plastic operation to improve the appearance of the mouth, because of the previous operations. I removed most of the old scar. Careful microscopic examination, made by Dr. Buxton, showed no evidence of sarcoma remaining. A few weeks later the patient complained of stinging pains on the site of the cicatrix, very similar to those she had noticed previously when the disease began to return, and there seemd to be a thickening in the scar. Injections were begun for a time and the pain disappeared. Shortly after this the patient returned to her home in British Columbia, and I am unable to give the later history.

There are other recent cases of interest that I could mention did the time permit It is true that sufficient time has not elapsed in these particular cases to justify one in claiming them as permanent cures, and they are not mentioned for this purpose, but merely to furnish additional proof that the mixed toxins have a specific action upon sarcoma. That this action is permanent and curative in a large number of cases is proved by a brief reference to my earlier cases already reported. The later history of these cases is as follows:

Case 1. *Spindle-celled sarcoma of the neck and tonsil.*—Tumor entirely disappeared under injections of the living bouillon cultures of erysipelas, producing an attack of erysipelas. Patient well six years later when last heard from.

Case 3. *Spindle-celled sarcoma of the abdomial walls and pelvis.*—Mixed toxins administered Jan. 3, 1893. Tumor entirely disappeared. Patient alive and well at present, seven years later. This patient was exhibited before the Academy of Medicine, March 1, 1900.

Case 4. *Spindle-celled sarcoma of the abdominal walls.*—Pronounced inoperable by Dr. M. H. Richardson of Boston. Microscopical examination by Dr. Whitney, Pathologist to the Mass. General Hospital. Tumor entirely disappeared and the patient is now well, six years later.

Case 5. *Recurrent spindle-celled sarcoma of the popliteal space and leg.*—Tumor disappeared. Recurred on and a

half years later. Amputation of the thigh. Recurrence in the gluteal region again treated with toxins; patient now well, six years after.

Case 6. Inoperable epithelioma of the chin, lower jaw and floor of the mouth.—Mixed toxins for three months. Growth disappeared. The patient was well when last heard from five years later. This patient was pronounced inoperable by Dr. George R. Fowler of Brooklyn, and the microscopical diagnosis made by Dr. Belcher, the pathologist of the Methodist-Episcopal Hospital.

Case 24. Very large recurrent inoperable sarcoma of gluteal region treated 1894.—Tumor slowly decreased in size and 5 years later there remained only a mass of pure fibrous tissue. Removed and examined microscopically. Patient in good condition 6 years later.

As to the risk attending the treatment, I believe that with the observance of proper precautions, it is nil or exceedingly slight. Including the early experiments in cases of carcinoma I have used the toxins in upward of 200 cases with but two deaths; both of which occurred more than four years ago. In estimating the percentage of cures it is well to remember that the treatment is advised only in cases of sarcoma in which there is no hope of cure from operation. In other words, in entirely hopeless cases. Of my series of cases, in a very large number treatment was begun after the disease had reached such an advanced stage that there was practically no hope of more than temporary improvement. To have saved even one case of inoperable cancer would seem quite sufficient to offset the disappointment of a hundred failures. If instead of one per cent there is a probability of being able to save upwards of 10 p. c. of these otherwise hopeless cases we certainly have sufficient encouragement to continue the method. I believe that the most promising field lies in the use of the toxins in small and safe doses directly after the primary operation, instead of waiting for a recurrence to appear. If the toxins can in a considerable number of cases destroy and permanently cure large inoperable sarcoma, it is reasonable to suppose that their administration after operation will destroy the invisible portions left behind, and thus in a much larger number of cases prevent subsequent recurrence.—*St. Paul Medical Journal*, June, 1900.

A CLINICAL STUDY OF HEROIN.

By JAMES R. L. DALY, M.D.
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A new agent in the treatment of cough, at present in wide use and attracting considerable attention in the medical world, is Heroin. It is a derivative of morphine—the diacetic acid ester—and is a white crystalline powder, almost insoluble in water, but readily soluble in water to which a few drops of acetic or hydrochloric acid have been added. It possesses many advantages over morphine as a respiratory sedative, among which the following may be mentioned: (1) It prolongs respiration, and at the same time increases the volume of each inspiration, making it a remedy much to be desired in the treatment of cough; (2) it is not an hypnotic; (3) absence of danger of acquiring the habit; (4) it does not weaken the respiratory apparatus; (5) it does not cause unpleasant disturbance of the stomach or intestines; (6) it can be prescribed in cases in which heart complications occur without risk of any deleterious effect upon that organ; (7) the ratio of the therapeutic dose to the toxic dose is considerably smaller than that of morphine.

The following cases taken at random from a clinical field of over 100 cases of pulmonary tuberculosis in all stages of the disease in this hospital will best serve to illustrate the efficacy of the drug:

CASE 1.—A. B., male, age thirty-two, clerk, entered hospital with history of pain in left side, which began about four months before admission; night sweats; hacking cough, most troublesome at night, with markedly diminished secretion and slight dyspnœa at varying intervals during day and night. Physical examination revealed consolidation of upper lobe on left side, and of apex on right side. Mist. codeia, one drachm, three times daily and at midnight was administered and continued for two weeks, but with little result. At the end of this period the codeine was stopped and Heroin substituted in doses of one-twelfth grain three times daily and at midnight. In four days the cough began to lose its hacking character, and the secretion became more abundant; in about one week the cough could only be observed in the morning and evening, and remained sufficiently loose to render the patient very comfortable. No dyspnœa was observed a week after the Heroin was begun, and breathing still remained free. Mean respiration during first twenty days in hospital, a.m., 29; p.m., 29 3-20. Mean respiration for twenty days following the first administration of Heroin, a. m., 24 6-20; p. m., 25 1-20. For the night sweats the

patient was given a pill of zinc oxide, two grains, with extract belladonna, three-tenths grain, for three nights without result. On the third night Heroin was substituted for codeine, and on the second night following the sweats ceased.

CASE 2.—On admission the patient complained of severe and painful cough throughout the day and night; expectoration scanty, and obtained only after considerable effort. Physical examination showed both lungs involved with cavity in right middle lobe. The patient was given Heroin, one-twelfth grain, three times daily at first, and shortly after the dose was increased to one-sixth grain. After one week of Heroin the cough was diminished to a marked extent, and the pain heretofore associated with the cough had disappeared.

CASE 3.—Patient entered hospital complaining of "smothering sensation" in chest, with slight pain. Heroin, one-twelfth grain, three times daily and at midnight, was administered, and in three days this "smothering" had disappeared, but not permanently, as the patient has since complained of it; but he says that it is not as severe or as lasting as before he was put on Heroin. Of course, the cough which was present was greatly loosened, and this it was that gave the patient relief.

CASE 4—Patient entered hospital complaining of hard, dry and persistent cough, most troublesome towards evening. Expectoration scanty, and effort of coughing caused great pain in chest. The patient was given Heroin, one-twelfth grain, and in three days the cough became soft, and expectoration became quite free. The pain in the chest had, of course, disappeared with the hard cough. The patient remained very comfortable for a month, when Heroin was discontinued, because I believed it to be the cause of a certain heavy feeling of which he complained. The cough, however, again became severe and hard, and Heroin was repeated in the same dose as before. In three days the patient was freed from the distressing cough, and that "heaviness" has not returned. Mean respiration during period in which the patient was taking Heroin, a. m., 24; p. m., 26. Respiration became more rapid while the patient was without the drug, averaging, a. m., 25 3-14; p. m., 27 11-14.

CASE 5.—Patient has been in hospital for some time. Complained of severe cough beginning about midnight and lasting until morning. Heroin, one-sixth grain, was administered every night at 10.30. The cough was absent on second night that Heroin was administered, and has not since distressed the patient.

CASE 6.—Patient complained of severe night sweats, and

was given atropine, 1-100 grain, for two nights without success; on the third night Heroin, one-sixth grain, was given one-half hour after atropine, and sweats ceased.

CASE 7.—J. F., male, age thirty-two, laborer. If any case can be said to be a striking example of the efficacy of a remedy, this case is certainly that one. The patient entered the hospital with very slight but hard cough and a history of marked and constant night sweats. The latter had inconvenienced the patient for seven weeks previous to entrance, without an intermission of a single night. Mis. codeia, one drachm, three times daily, was administered for the cough, and an attempt was at once made to check the night sweats. Camphoric acid had been a favorite with me in the treatment of this symptom, and I accordingly gave 20 grains at bed-time, and repeated the same dose for four succeeding nights, but without result. Then atropine sulph. and ac. sulphuric aromat. were tried in the proportion of one-fiftieth of the former and 10 minims of the latter, but again without a favorable result. This was given for five nights. Atropine sulph. alone was tried in dose of one-fiftieth grain for a week; still no response. Next was tried a pill of zinc oxide, two grains, and extract belladonna, three-tenths grain, for five nights, and this, like the rest, failed. Pilocarpine was next tried in dose of 1-100 grain, but it only increased the sweating. Next in order came warm baths, and then bathing with ac. sulphuric dilute, but these met the same fate as all the preceding. Then I decided to give the sweat glands a rest, and for a week nothing was administered for the sweating, and at the end of this time atropine sulph. was repeated in doses of one-fiftieth grain, but without result, until about the fifth night of the administration of the latter the codeia mixture was discontinued and Heroin substituted in dose of one-twelfth grain three times daily. On the third night of the administration of the latter the sweats decreased to a great extent, and on the fourth night ceased altogether. The Heroin had replaced the codeia mist., not because of the sweating, but because of the hard cough, which did not improve; and since the patient had been taking the former the cough has loosened considerably, and he now experiences marked relief. I regard this case as typical, not of the curative effects of Heroin on the night sweats, but rather of the quality of the drug to assist the ordinary anhydrotics when, given alone, they fail.

CASE 8.—Case of tubercular laryngitis. Patient complained of severe sore throat, which prevented deglutition. Pills of Heroin, one-twelfth grain, were administered every

three hours, and kept the throat in a condition of anesthesia for about one to two hours, rendering the patient fairly comfortable, and most of the time free from pain. It is unnecessary for me to mention that the patient was instructed to dissolve the pill slowly on his tongue. Two other marked cases of tubercular laryngitis were temporarily relieved by the administration of Heroin in this manner.

These cases are fair samples of the results obtained by the administration of Heroin. In almost every case in which it has been tried it has been of some service in the alleviation of cough, be that service ever so slight. Even the advanced cases have been to a certain extent relieved. I found, however, that the more favorable results were obtained in those cases in which the disease process had not advanced to too great an extent. In this class of cases the drug never failed to loosen a hard cough and produce free expectoration, giving marked relief from pain when present. I regard it as unequalled as a sedative in the treatment of cough of pulmonary tuberculosis, and venture to say, although I have not tested it in cases of cough in other pulmonary affections, that it will act equally well in such cases.

The smaller dose of one-twelfth grain is sufficient to afford relief in most cases, certainly in the milder or earlier one, but in some instances it was found necessary to increase the dose to one-sixth grain, as after a time the smaller dose seemed to lose its effect upon the patient. Sometimes when Heroin had been taken for a long time, it was found to be a good practice to stop it and give codeine, or some other sedative, for one week, and then renew the Heroin at the end of this time. In this way the drug acted as well when renewed as in the beginning of the treatment. It is true, however, that Heroin produces its effect for a much longer period than does any of the other sedatives used in this affection.

I said it was not a hypnotic, but the fact that it relieves the distressing cough which is often the cause of many sleepless nights, and thus ensures a natural sleep, obviating the necessity of using hypnotics, should not be over-looked.

I have very carefully watched the temperature charts for any evidence of its action as an antipyritic, but have been unable to find that it produces any effect whatever on the temperature. It certainly possesses no quality as a preventive or cure of the chills so persistently present in the later stages of tuberculosis. Like the respiration, the pulse is rendered fuller and slower. In 10 cases observed the mean pulse rate was reduced about four beats per minute; in one case the rate was reduced eight beats per minute. By its action upon

respiration and its ability to relieve cough and promote excretion of secretory products, it manifests a decided effect upon the dyspnea.

I regard the influence of Heroin on the night sweats as second only in importance to its influence as a sedative for the cough. In the cases cited its quality as an adjuvant to the ordinary remedies in checking the sweats is well marked. In six other cases favorable results were obtained in either checking or markedly decreasing the sweat by the administration of Heroin in conjunction with one or another of the ordinary anhydrotics. Its action in this particular is best appreciated after meeting failure in using the ordinary agents alone.

The cases of tubercular laryngitis mentioned are typical of its action as an analgesic in the treatment of the painful throats of this affection. In these cases it afforded considerable relief from pain for periods of about one to two hours following the administration of the pill.

In regard to its influence on respiration, I have carefully noted 19 cases, and have found that in each case the mean respiration a. m. and p. m. has been reduced from two to five, and in some cases as high as seven per minute.

No action in the intestines was observed, except, perhaps, a slight tendency to constipate if given in larger doses than one twelfth grain. Of this, however, I will not be certain, as in the great majority of cases this action was not apparent. In some cases it has been noticed to cause a disturbance of the stomach. One patient complained that the drug caused considerable nausea shortly after taking, while with others the disturbance can best be described by using a term applied by a patient to the condition of his stomach after taking Heroin—"squeamish." One complained of complete loss of appetite whenever he took the drug. In all, some disturbance was noted in five cases out of upwards of 70 patients taking the drug. I should add however, that two of those who complained of disturbance of the stomach while taking Heroin were later able to use it without noticing any ill effects. Another, and, in my opinion, the only real objection to Heroin, is that in certain cases the larger dose of one-sixth grain was found to cause a feeling of heaviness during the day. To quote a patient, "I feel heavy and as though I want to sleep, but if I tried to do so I find that I cannot." This was observed in four cases. The drug did not in any instance produce this effect when given in the smaller dose. But the chief use to which Heroin can be put is as a sedative for the cough and to prevent the distressing

and disagreeable stagnation of secretory products in the lungs, particularly in cases of pulmonary tuberculosis. No drug can compare with Heroin in this particular. Cases that have come into the hospital with painful and almost constant cough, with inability to raise the sputum, resulting in fetid breath and more or less dyspnea, have been almost immediately relieved of pain, and the expectoration rendered freer, with decrease in the dyspnea, by the administration of Heroin in doses of one-twelfth grain three times daily.—*Boston Medical and Surgical Journal,* February 22, 1900.

Progress of Medical Science.

MEDICINE AND NEUROLOGY.

IN CHARGE OF

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SERUM DIAGNOSIS OF TYPHOID FEVER.

William G. Savage, in the *Clinical Journal* of May 2, 1900, says that the so-called Widal test depends upon the clumping and cessation of movement in a broth culture of the typhoid bacillus when seen in a hanging drop. We cannot say in every case where clumping or cessation of movement occurs that the patient from whom the blood was taken is suffering from typhoid fever. Sometimes the bacillus typhosus in a broth culture will clump spontaneously. This source of error is easily eliminated by examining the culture before the serum is added. The cause of this spontaneous clumping is not known. Another source of error is where an examination is being made for suspected typhoid and the disease may be either influenza, anemia, or some other condition easily confounded with it. In such cases the patient may have had typhoid fever years before. It is claimed that the Widal test may be obtained years after the infection. Errors in such cases are difficult to avoid.

Normal serum, if diluted slightly, say one in ten, may in certain cases cause some clumping. If the serum be further diluted and again examined with typhoid broth, these changes do not take place. The writer believes that if the serum be sufficiently diluted, clumping with normal blood never takes places. A dilution of one in thirty or one in fifty, or even higher, is necessary to prevent failures from

this source. The sera of diseases other than typhoid are cited by some writers to give positive reaction. Cabot points out that scarcely any two observers find these pseudo-reactions in the same diseases, and in all probability, with a careful technique and perfect dilution of the serum, they never take place.

The blood in enteric fever does not always give a characteristic reaction. This may be divided into three classes: (*a*) The test may be made too early in the course of the disease; the reaction is generally obtained about the end of the first week. (*b*) There are cases in which the reaction is known to intermit; for example, it is present one day, absent the next, and again present the next day or in a few days. These cases are probably very infrequent and do not seem to be a common cause of error. (*c*) A few cases of proven enteric fever yield no serum reaction throughout the disease.

The first two causes of absence of reaction obviously teach that in negative cases we should repeat the examination of the blood at a subsequent date. A negative reaction, though not so valuable as a positive one, is yet of great value. Efficiently performed, the test is correct in from 90 to 95 per cent of the cases.

In collecting the blood for making an examination, it may be done by allowing a drop to dry on a glass slide, or it may be drawn into a capillary pipette and the ends sealed. The latter permits of the serum being separated from the blood without the admixture of corpuscles thus making it somewhat more accurate. If the dried blood is used it is mixed with a little water of inert fluid, and a small quantity is taken up in a loop.

Care should be taken in obtaining the typhoid bacillus, as those which have a tendency to clump spontaneously are valueless. Some cultures of the typhoid bacillus give a prompt reaction and others do not. The author describes one case in which the test was made with four different cultures of the typhoid bacillus. In one a well marked reaction was obtained, in another it was doubtful, and in the remaining two there was no reaction. He uses a culture of agar from two to six weeks old kept at room temperature. From this a tube of sterile broth is inoculated and grown at 37° C. This culture should not be more than twenty-four hours old if grown at a high temperature.

The serum diagnosis of typhoid may be carried out without the aid of a microscope, by what is known as a sedimentation method. This, by some writers, is considered even

more valuable than the microscopic test, and is performed by diluting the serum, which for this purpose must be obtained in capillary tubes with twenty-four parts of normal saline solution, and then added to equal parts of a fresh broth culture of the bacillus typhosus. If at the end of twenty-four hours the solution shows a uniform turbidity, the reaction is negative. If, on the other hand, well marked plugs are seen at the bottom of the fluid or along the sides of the tube, the reaction is positive. The method requires no watching, but performs itself.

BICHLORIDE BATHS IN THE TREATMENT OF VARIOLA.

H. A. Ingalls (*Journal of the American Medical Association*, April 28, 1900) has treated thirty-six cases of variola, of which one was hemorrhagic and thirteen confluent, without mortality, by means of these baths. The first case was seen in the papulovesicular stage, of confluent type. It was noted that the pustulation and pitting were much less than might have been expected in so severe a case. The baths were comforting, and there was but a trace of the peculiar odor of the disease. The method of giving the baths was to take a six-foot tub which was filled with fairly warm solution of the bichloride, 1-to-10,000. The temperature ranged from 103° to 105° F. The patient was placed in the tub and rubbed with a soft cloth, the bath lasting from ten to twelve minutes. Afer removal from the bath patients commonly expressed much relief, but shortly after, owing to the drying off, complained of a burning sensation, which led to a routine practice of anointing the patients after a bath with a mixture of subnitrate of bismuth, carbolic acid, and olive oil.

COLD IN THE HEAD.

Dr. A. S. Barnes, in the *Interstate Med. Jour.*, says that a quick method to cure a cold in the head consists in a hot bath and warm bed; one-eighth of a grain of pilocarpine muriate is then administered, and, after three-quarters of an hour of sweating, one one-hundredth grain of atropine is taken. This is followed by a prescription containing phenacetine, salol and caffeine citrate at intervals of two hours.

CHRONIC CONSTIPATION IN CHILDHOOD.

Heinrich Dœrfler has, for the last six years, met with flattering success in the treatment of chronic constipation

in children by the administration of butter. It should be fresh, and of the best quality. It should be given in the natural state, and not by means of any vehicle. For the first month clysmata may be given; in the second and third month from a half to a whole coffeespoonful of butter daily morning and evening, till the stools are normal; then only every two days. The dose is further increased according to the age.—*Medical Record.*

PRURITIS ANI.

An injection of ergot, hydrastis and carbolized oil of two drachms into the rectum is given first. If the skin is hard it is painted with a saturated solution of silver nitrate every third day for three visits. Then every day citrine ointment is used and bound on with a cotton pad. The itching at night may be relieved by extremely hot water, followed by black ointment or calomel salve, being careful not to scratch the skin. This daily routine is followed for six weeks, then at longer intervals for six months, never stopping in less time, but occasionally going longer. Of two hundred cases thus treated, permanent cure resulted in every case, many cases having been observed for five years. As the author considers the lithic acid diathesis a prominent constitutional cause, this must receive internal medication and the bowels must be moved every day.—*Phil. Med. Jour.*

ON THE CARE OF ARTIFICIAL TEETH.

The fortunate possessor of a healthy olfactory nerve must have frequently observed the peculiarly offensive breath found only in those who wear a toothplate. By a little care and proper management, this trouble may be avoided. It goes without saying that no one can enjoy ideal health while compelled to breathe foul air, whether the cause be extrinsic or intrinsic. There *are* dentists who advise their patients to never remove the plate from the mouth except long enough to clean the teeth after eating. But most of them, I think, will say that in the vast majority of cases it is not necessary to wear them during sleep, at which time they should usually be kept in pure water, to which, if desired, a little salt may be added.

It will thus be found practicable to keep the teeth free from a bad odor, and the mucous membrane of the mouth in a healthy condition. After each meal, if convenient, water at near the boiling point, should be gradually poured upon the teeth and allowed to remain until sufficiently cool to

permit the use of a brush. The dark stain which comes upon the teeth and the rubber plate may be removed by a ten per cent solution of chemically pure nitric acid, or by pumice. After eating meat, care should be used to remove every particle which may have found its way into the interstices.—*Med. Times.*

SIMPLE TREATMENT FOR PERSISTENT VOMITING.

Dr. Mitchell states that he has succeeded frequently in overcoming persistent vomiting by the aid of cold compresses. The method he uses is to wring towels out of ice water and to change them every minute until the vomiting ceases. It takes from fifteen to twenty minutes to stop the vomiting.—*Medical Summary.*

TO CONTROL HIGH TEMPERATURES.

Dr. C. C. Booth (*Phil. Med. Jour.*) suggests the following method of reducing a high temperature: "The patient is stripped entirely of all clothing, placed upon rubber sheet and covered with one thickness of a piece of cheese-cloth two yards long and the usual width, one end having been split so that each leg can be covered separately. A nurse is directed to squeeze water at about the temperature of the body from a sponge, over the entire anterior surface of the body, and to wet the gauze freely as often as necessary to supply the water for evaporation. A case of typhoid fever, with persistent high temperature, is reported, in which this method was used. From the beginning of treatment the pulse, nervous system, temperature, strength, and every symptom rapidly improved. The idea originated upon observing the depression of the wet bulb of a wet and dry bulb hygrometer caused by the evaporation of the water from the gauze, which is applied tightly to the bulb containing the mercury. All that is claimed for this method is that it is more convenient, more easily applied, less dangerous, cheaper and pleasanter to the patient than any other method. The gauze is to be kept wet until the temperature is reduced to normal."

NIGHT SWEATS.

Few practitioners appreciate the exceedingly great value of agaricin as a remedy in night sweats, especially those of phthisis. The most profuse sweat is checked almost by magic, with a single dose. It operates by diminishing thirst and increasing the secretion of urine. The dose may be pushed

to the extent of one grain in the course of twenty-four hours. The single dose for an adult is from one-eighth to one-fourth of a grain.—*Technics.*

INFANTILE CONVULSIONS.

Dr. R. S. Roland, of Sylvain, Tex., says the physician is seldom called to a case until the child has had one or more convulsions, and is often in the dark as to the cause; however, the general treatment is about the same in all cases. If they are due to some pathological state, special treatment should be directed to it.

Now, when called to a case, do not spend too much time trying to get at the cause, but go right to work. Place lower extremities in hot mustard water, or give a general warm bath from five to fifteen minutes, according to the severity of attack, with cold to the head; give an enema of soap and water. Syrup of ipecac as an emetic if something indigestible has been taken recently; bromide of potassium and chloral hydrate, according to age, every ten minutes until the convulsions cease. In those subject to attacks their hygienic surroundings should be the best.—*Medical Summary.*

PAIN.

Pain of a neuralgic or drawing character in the neighborhood of the heart is found as the result of several causes, as a rule, in the following order of frequency:

1. Pain with palpitation of the heart from the accumulation of flatus in the transverse colon just as it turns to descend. Many patients who go to the physician complaining of heart disease suffer only from this condition, due to fermentation in the large bowel. Again, the pain due to gastralgia, or, as it has been called, cardialgia, may be referred to the heart by the patient.

2. Intercostal neuralgia due to debility. In these cases tender spots will often be found, one in the precordium, another in the outer edge of the scapula, and a third on the vertebral column. These are sometimes called "spots of Valleix." In other cases the pain will be due to spinal trouble, anemia, or tight lacing of corsets.

3. Pseudo-angina.

4. True angina.

5. Locomotor ataxia.—H. A. Hare, in *Practical Diagnosis.*

AIDS TO DIGESTION.

By lying on the right side for fifteen minutes after a meal all the liquid would gravitate out, leaving the solids to be acted upon by the gastric juices. Also, that when the bile flowed back into the stomach producing vomiting, taking the recumbent position on the right side would soon stop the vomiting. The rule of lying on the right side for fifteen minutes after each meal is one of the best treatments for dyspepsia. Again, before rising in the morning one should lie a half hour on the left side, thus emptying the colon. In dysentery and diarrhea one should immediately, after each passage, lie down down on the right side. As soon as it is necessary again to evacuate the bowel, then turn on the left side a moment before rising. Thus we will prevent accumulations in the lower bowel that produces tenesmus. When the bile becomes very acrid, and the digested products fermenting instead of the usual healthy products, this matter parboils and inflames the intestine, and more especially the colon where the small intestine is attached; therefore, by freeing the colon, flushing it, the cause is removed and the inflammation subsides and the "appendicitis" gets well. Gravity, water and common sense are wonderful doctors.—*Med. Visitor.*

NASAL OBSTRUCTION.

The *Medical Age* says: F. R. Reynolds states that by the successful treatment and permanent relief of nasal stenosis many diseases are prevented, relieved, or cured, Among these are anemia, marasmus, hay-fever, asthma and laryngismus stridulus. Reflex cough may be due to hypertrophic rhinitis. Also, gastralgia, cardiac palpitation, neuralgia of the trigeminus, scotoma, migraine, cephalalgia, ciliary neuralgia, vertigo, photophobia, neurasthenia, spasmodic cough, spasm of the glottis, frontal and supra-orbital headache may all have their origin in an exciting nasal focus. Emphysema and bronchitis often accompany nasal stenosis. Nasal stenosis not rarely has a deleterious effect on the ears.

INFANTILE SCURVY.

There are two affections occurring in children for which scurvy is particularly mistaken; acute rheumatism and acute anterior poliomyelitis. There is practically no reason at all why scurvy should be confounded with the latter disease. There is, of course, absence of movement in the limbs in both

cases, but in anterior poliomyelitis this is due to inability to move them because of palsy; in scurvy the failure of movement is due to pain. This can very easily be decided by passive movements. Scurvy and acute rheumatism are not so easy to differentiate. In scurvy, however, the hemorrhage is not into the joint and not into the epiphysis, but practically always into the diaphysis of the long bones. Blood extravasations occur at times over the tissue and occasionally even over the carpus, but these are rare exceptions. If the bones are protected from motion, it will be found that the joints in scurvy may be freely moved. At times, in scurvy, hemorrhage occurs into the joints, and this may almost hopelessly confound the disease with rheumatism; but these joint hemorrhages are very rare.—A. JACOBI, *Medical News.*

INTESTINAL REST IN TYPHOID.

IT IS AN AXIOMATIC PRINCIPLE IN BOTH SURGERY AND MEDICINE THAT A CONGESTED OR INFLAMED PART NEEDS REST.

The surgeon recognizes this when he immobilizes the fractured bone and retains the fragments in apposition; the physician likewise appreciates the great importance of this principle in cases of gastric ulcer when he feeds his patient by the rectum in order to avoid irritating the inflamed part, either directly, or by exciting gastric motility. Although typhoid fever is essentially a systemic disease, its characteristic local lesion is the intestinal ulcer, which should, as far as possible, be *kept at rest.* Milk, which has heretofore been regarded as the only proper exclusive food, is, as a recent writer says," not a liquid diet, but a deceptive solid" —capable of filling the small intestines with dense indigestible curds which scratch and irritate the ulcerated bowel, and in addition, ferment and cause gaseous distention, tympanitis, etc. *Liquid Peptonoids*, on the other hand, is open to none of these objections. Its administration *affords rest* to the ulcerated intestinal tract, because :

1st. *It is pre-digested*, and therefore promptly absorbed from the stomach, leaving no residue for the bowel to dispose of.

2nd. *No curds* are formed as from milk.

3rd. *It is absolutely aseptic* and cannot cause fermentation, tympanitis or increased peristalsis, resulting in diarrhea.

4th. *It has the requisite nutritive power* to maintain life for weeks and even months, especially in febrile conditions.

Another advantage of *Liquid Peptonoids* is its *pal-*

atability, which renders it grateful to the patient, especially when given ice cold.

From one to two tablespoonfuls every two, three or four hours, should be given as necessary. When an efficient intestinal antiseptic is required, as it very frequently is in this disease, *Liquid Peptonoids with Creosote* provides both food and remedy at one and the same time. The unpleasant taste of the Creosote is almost entirely abolished in this combination. Each tablespoonful contains two minims of pure beechwood creosote and one minim of guaiacol, its active principle.

SURGERY.

IN CHARGE OF

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FRACTURES OF THE ANKLE.

There are three little practical points of importance to be emphasized in connection with the treatment of fracture of the ankle: *First*, whatever other precautions may be taken in the treatment of this fracture to obtain a good result, one should always place the foot at a little less than a right angle. *Second*, in case of a painful joint following Pott's fracture, the foot should be fixed for a period of about six weeks at a little less than a right angle, the patient being permitted to walk without the use of a crutch. *Third*, this can easily be accomplished by applying the plaster-of-paris cast with the knee in a flexed position.

If these practical points are observed, fractured ankles are not painful after the fracture has healed, and those which are painful after other methods of treatment will be free from pain in a few weeks, notwithstanding the fact that they may have resisted the ordinary forms of treatment for weeks, or months, or even years.—A. J. OCHSNER (*Amer. Jour. of Surg. and Gynec.*)

THE TREATMENT OF WENS BY THE INJECTION OF ETHER.

Emile Sergent, Paris, has used injections of ether into wens with good results. The quantity to be injected varies with the size of the tumor. If the patient complains of pain the syringe may be detached from the needle for a few minutes, then reattached and more ether injected. Four or five injections, every other day, always the same site, will be followed by liquefaction and the contents may be expressed. The sac will become less adherent; the few adhesions remaining may be broken up by introducing a stylet through the small original wound and the sac then slowly drawn out. Dr. Sergent claims these advantages for his method. It is not painful, not bloody, not dangerous, is easy to do and leaves no scars. The latter is an especial advantage where the wen is situated upon the face.—*La Presse Med., St. Louis Medical Review,*

FISTULA IN ANO; ITS RELATION TO PHTHISIS.

S. G. GANT, New York, concludes his discussion of the subject with the following observations, which summarize his views: (1) Tuberculous fistula of the anus is usually secondary to tuberculous disease of the lungs. (2) Pulmonary phthisis is rarely, if ever, secondary to fistula in ano, either before or after operation. (3) Tuberculosis of the anal region should be dealt with radically, as is recommended when it attacks other parts. (4) When the patient's general condition will permit, we should operate on all fistulæ, irrespective of the kind. (5) We should not refuse to operate on persons suffering from a mild form of phthisis, nor on those who give a family history of tuberculosis. Certainly, if we arrest one destructive process, nature is all the more capable of dealing with the other. (6) Those patients operated upon for tuberculous fistula and those that are non-tuberculous complicated by phthisis, who rapidly decline and die, do so as the result of an inflammation of the lungs induced by the anesthetic, especially ether. Such accidents have not followed any of the operations which the writer has performed under local anesthesia. (7) He believes that we are justified in discarding the erroneous teachings of writers who believe that the cure of a fistula will result in a development of phthisis.—*N. Y. Med. Record.*

FORMALIN AS AN ANTISEPTIC IN GENERAL SURGERY, GYNECOLOGY AND OBSTETRICS.

G. E. CRAWFORD, Cedar Rapids, Io., is convinced from his own experience that formalin, the 40-per-cent. solution of formaldehyd, comes nearer meeting all the requirements of a perfect disinfectant than any other substance yet employed. Its germicidal potency ranks with that of the two or three most efficient bactericides, and its inhibiting power is probably greater and more lasting than that of any of them. It is not only an antiseptic, but a deodorizer as well, and solutions of potent strength are much less irritating, both to the hands and to wounds, than any other equally efficient antiseptic. It is not injurious to instruments and it is practically innocuous. Large cavities can be freely irrigated, even the peritoneal cavity, and a considerable quantity of the solution can be allowed to remain without injury or danger of toxic effect. The solutions that have generally been recommended are too strong. The strength of a solution depends upon the amount of formaldehyd it contains, and it should be remembered that this is two and a half times stronger than formalin. The latter is a definite substance, and is the tangible form in which we employ formaldehyd as an antiseptic in surgery; therefore the percentage of a given solution should be that of formalin and not that of formaldehyd. The solutions of formalin commonly used are the eighth, fourth, and the half per cent.; the two former for washing infected wounds and irrigating and packing cavities and sinuses, and the latter for disinfecting the hands and the surface of the body. They contain formaldehyd in the strength of one two-thousandth, one one-thousandth, and one five-hundredth respectively. The half per cent. solution is of about the right strength for the hands. In gynecologic practice, formalin is extremely useful; the peritoneal cavity can be freely irrigated with the one two-thousandth solution in cases of pelvis abscess, pyosalpinx, etc., where purulent matter has escaped into the cavity. It is superior to iodoform in packing and drainage of sinuses, while in obstetric practice it meets all the requirements of an antiseptic to disinfect the hands and the external parts.—*N. Y. Med. Jour., St. Louis Med. Review.*

INGROWING TOE-NAIL.

The following treatment is very strongly recommended by Dr. Kinsman in the *Columbus Medical Journal:*

1. Remove all pressure from the nail by cutting away a piece of the shoe.

2. Disinfect with hydrogen dioxide until no more "foam" appears.

3. Apply a drop of soft solution of cocaine in the base of the ulcer.

4. Apply a drop of Monsell's solution in the ulcer, then cover loosely with gauze. Repeat this process every second day until the edge of the nail is released by the retraction of the hypertrophied tissue. The patient suffers no pain from the application, and all pain has disappeared the second day. The cure is effected in a week or two without inconvenience or interference with business.—*Texas Medical News*, July, 1900.

STRANGULATED HERNIA IN CHILDREN.

Coley, W. B. (*The Journal of the American Medical Association*, Vol. xxxiv., No. 6) says:—

Strangulated inguinal hernia in infants and children is not so rare as might be supposed. He has operated on eight patients under two years of age, with one death. The fatal case was in an infant of eight weeks who was moribund at the time of operation.

In four of the cases the sac contained cecum, and in three of these four the appendix was also found. The author believes that, as a rule, the neck of the sac is not the cause of the constriction. With scarcely an exception herniotomy may be supplemented by an attempt at a radical cure.

The diagnosis of strangulated hernia in children is not usually difficult, though it may be confined with hydrocele of the cord.

Gentle taxis for two or three minutes may be tried. If, after a second attempt to reduce the hernia has been made by taxis, preceded by the application of hot cloths, there is no result, the operation should be done without further delay. Temporizing is often the cause of death.

TREATMENT OF FRACTURES OF THE PATELLA.

Dr. Will H. Means (*Columbia Medical Journal*) offers the following conclusions to an interesting article: 1. The

results of a non-operative treatment are unsatisfactory both as to long confinement and functional disability. 2. The methods of maintaining apposition of the fragments by external appliances are unsatisfactory and unscientific. 3. In open arthrotomy the fragments can be carefully approximated and sutured in such a manner as will maintain apposition and, ultimately, bony union. 4. The operative method saves months of confinement, and gives permanent results. 5. The buried suture material should be absorbable, such as catgut or kangaroo tendon. 6. The field of operation should be continuously irrigated with a hot salt solution during the manipulation, and the incision closed without drainage. 7. The massage treatment begun at an early date is an important factor in restoring functional activity of the joint.

OBSTETRICS.

IN CHARGE OF

H. L. REDDY, M.D., L. R. C. P., London,

Professor of Obstetrics, University of Bishop's College; Physician Accoucheur Women's Hospital; Physician to the Western Hospital.

MANAGEMENT OF PUERPERAL INFECTION.

F. W. Sears states that we are often called upon to attend patients when the system has been severely taxed by the amount of poisons absorbed from the products of putrifaction, and it is our purpose to arrest this absorption by the safest and the quickest way. The finger or fingers of the physician passed into the uterus to remove portions too large to be washed away, or to serve as a guide to their removal by a pair of small placental forceps, and this followed by a thorough intra-uterine irrigation with sterilized water, or any other aseptic non-irritating solution will most effectually stop the absorption. If, after repeated irrigations, we fail to relieve the symptoms, we may find it necessary to resort to the curette, and this should be done carefully and thoroughly, remembering also that there is danger of perforation, and, if any septic material is left, an increased absorption. After curetting, the uterus should be irrigated and packed with gauze. If there is a sudden rise of temperature, the gauze should be removed and the uterus irrigated. In septic cases he believes that the curette is contra-indicated. Here fre-

quent irrigations with a safe antiseptic solution should be our main local treatment. In giving a uterine douche, Sears prefers an ordinary curved glass irrigator.—*Am. Jour. Obstet.*

PUERPERAL MASTITIS.

Brouha reports such a case on account of its occurrence at a period soon after labour. The first symptoms were noticed within twelve hours after delivery and before the child had been nursed. No causative lesion of the breast could be found, and no infection of the genital tract was present. The writer attributes the mastitis to the efforts before labour to obtain perfect cleanliness of the nipples, during which the germs may have entered the breast through some slight solution of continuity of its surface.

PAIN AS A PATHOGNOMONIC SYMPTOM OF ECTOPIC PREGNANCY.

Henry C. Coe states that pain alone, when not accompanied by a clear history of menstrual irregularity, symptoms of pregnancy and the presence of a tumor at the side of the uterus or in Douglas' pouch known to be of recent development, is pathognomonic of extra uterine pregnancy only under certain conditions, viz.: The pain is of a sharp colicky character, distinctly localised on one side, attended with fainting more or less marked, and is usually followed by intervals of hours or days of complete remission. The pulse is accelerated during the attacks, and there is no rise of temperature. The latter is an important symptom, distinguishing ectopic from inflammatory conditions. The violent tearing pain attending intraperitoneal rupture is accompanied by the unmistakable evidence of internal hemorrhage. In extraperitoneal rupture the symptoms vary in severity according to the amount of blood lost, but soon subside, being succeeded by the usual evidences of pressure resulting from a mass in the folds of the broad ligament which dispels or displaces the pelvic organs. A persistent pain following the acute attack may indicate localised peritonitis.

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By J. T. DONALD, M.A., Professor of Chemistry, Medical Faculty, Bishop's College, and Analytical and Consulting Chemist and Assayer.

MONTREAL, June 14, 1894.

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Sulphate of Sodium	.210	Carbonate of Lime	2 940	In 10,000 parts of water	20.899
Sulphate of Magnesia	1.262	Carbonate of Iron	Traces.		

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(Sgd) J. T DONALD.

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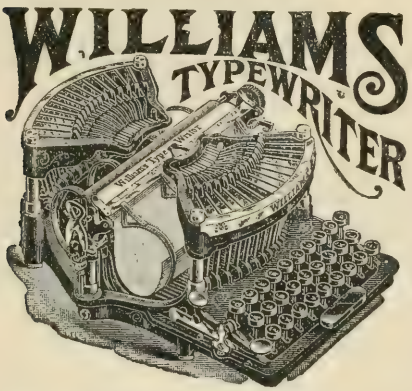

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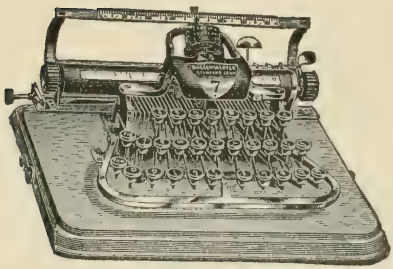

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Editorial.

GUN-SHOT ABDOMINAL WOUNDS.

The present South Africa war is rich in surgical lessons, but none are more striking and unexpected than that which has reference to gun-shot wounds of the abdomen. Even as late as the meeting of the British Medical Association held last summer, the consensus of opinion seemed to be "that even if the most remote chance of wound of the gut existed, the abdomen should be opened at the earliest possible moment." With this opinion, so to speak, ringing in their ears, the members of the Royal Army Medical Corps went to the war determined to avail themselves of every possible opportunity to deal scientifically with this class of wounds. This war seemed likely to present opportunities, such as had never occurred before, to practice modern abdominal surgery. But, very early in the campaign, it was recognized that such anticipations were not justified by results. Sir William MacCormac, Mr. Treeves and others who have world-wide reputations as surgeons, tell us that such anticipations were not realized, and that just the contrary was their experience. Water was scarce, and what was obtainable was abominable, filthy and impossible to make pure. By reason of this want, also that of towels and of many other needed articles, by

reason of the plague of flies, and the want of sufficient help, an ideal aseptic operation was found absolutely impossible.

But even supposing that they had been available, there was found wanting the opportunity to attend such cases at the precise moment opportunate to possible success. After an engagement, the wounded were brought in, in such immense numbers that it was found an absolute impossibility to postpone attendance upon them that a few abdominal wounds might be attended to with that precision which a prolonged operation requires. At first this seemed to be viewed by the Medical Officers with deep regret. As time wore on, however, this regret seems to have turned into rejoicing, for subsequent experience has shown that operation for gun shot wounds is seldom needed. In the few cases where an operation was performed, it was clear that the puncture made by the bullet was small—so insignificant that it was very difficult to recognize, especially after the lapse of a very few hours, and that leaking had not occurred to any appreciable extent. It was soon recognized that the wound of a Mauser bullet was entirely different from anything previously met with. The wound was found to be so small that one, or, at most, two, Lembert sutures was sufficient to close them. It was also noted that extravasation of the contents did not occur, either because of the "ponting" of the mucous membrane or because the gut was motionless. More than one medical officer has suggested that this condition is due to the impact of the swiftly moving bullet inhibiting the peristaltic movement, or, as it were, "stunning" the intestine. The bowel wound was found to close rapidly, and the general opinion seems to be held that this especially occurred where the patient had been long without food, many of these cases being in men who had had little or no food for a considerable time. In fact, it has been found that the majority of abdominal gun-shot wounds were best treated by the expectant method, and under such treatment it is estimated that fully sixty per cent. recovered. Final deductions are, of course, as yet out of order, but Mr. Treeves has expressed the opinion that "most cases of wound below the umbilicus do well if left alone."

It has seldom happened—possibly never before—that any steamship on a single trip has had its passengers exclusively composed of medical men. Yet this occurred when the magnificent steamship "City of Rome" sailed out of New York on the 30th of June, with three hundred medical men, many having with them their wives and members of their families. This large party was organized by three physicians. It was intended to make a tour of Scotland, England, Germany and Switzerland, before reaching Paris, where as many as desired could attend the International Medical Congress. The trip was to last thirty-eight days and cost $260.00, including hotel expenses, carriage fares, and all necessary fees for sight-seeing. We feel sure the party was a jolly one and that a good time was enjoyed by all.

We congratulate our contemporary, the *L'Union Medicale*, on its greatly improved appearance. To-day it is not excelled by any medical journal in Canada in its outward look, and its contents bear a most favorable comparison with any. Long may it live and flourish, a monument of the rapidly advancing status of the Canadian medical profession.

TREATMENT OF INOPERABLE CANCER.

We publish, as a selected paper in this issue of the RECORD, an article on the treatment of Inoperable Cancer, by Dr. Colley, of New York. It is of very great importance, in view of the fact, admitted on all sides, that the last few years has seen a marked increase of this disease. Owing to our limited space we have cut out a number of the reports of the newer cases treated, as well as some of those recording the further results in the cases first reported. Sufficient however, remains to give our readers a good idea of this new form of treatment.

The *Medical Fortnightly* draws attention to the somewhat singular fact that of the presidents of the American, Medical Association elected since 1880—twenty-two in number—eighteen have been chosen from the ranks of surgeons or surgical specialties. Internal medicine has had two

representatives, and the general practitioner has been honored twice. This is a unique fact, and one which emphasizes the conditions of medicine in the United States, and is in striking contrast to its sister association—the British Medical. While finding no fault with the personnel of those selected to fill the chair of the American Association, it urges the claims of medicine for a division of the honor. It also adds that no one could more fittingly bear the honor than our old friend, Dr. William Osler (a Canadian), of Johns Hopkins' University, "the leader of internal medicine on this continen', if not the English world." It asks for his election to the presidency in 1901.

PERSONAL.

The Hon. Dr. Borden, Minister of Militia, will, it is said, sail shortly for England. The trip will be to seek rest, while, at the same time, he will transact some business with the War Office.

Dr. Fiset, one of the surgeons of the 2nd Battalion Royal Canadian Regiment serving in South Africa, was, a short time ago, taken prisoner by the Boers. He was recently released, and has rejoined his regiment. His return was warmly greeted, for he is a universal favorite with both officers and men.

The death in action, near Pretoria, of Lieut. Harold Borden, of the Canadian Mounted Rifles, only son of the Hon. Dr. Borden, Minister of Militia, is deeply regretted by all who knew him. A Third Year medical student at McGill University, he gave promise of a brilliant future. The blow is a severe one to his father, as he was an only son, and his death breaks a record of several generations of medical men. He died with his face to the foe—for Queen and Empire—the Commander-in-chief, Lord Roberts, having had his gallantry brought more than once to his notice. Personally known to him, the writer grieves at his death and the loss of a dear young friend.

Surgeon Capt. Sanford Fleming, Princess Louise Guards, has been appointed A.D.C. to Major-General O'Grady—Haly, the new Commandant of the Canadian Militia.

Dr. Craik, Dean of McGill Faculty of Medicine, was recently entertained to an informal supper at St. James' Club. During the evening he was presented with a beautifully illuminated address accompanied by his portrait in oil.

Lieut.-Col. Neilson, Director-General Militia Medical Staff, has gone for two weeks' fishing to the lakes north of Quebec.

The death early in July of Dr. Fafard, Professor of Chemistry in Laval University, Montreal, was an unexpected event. He was a strong member of the Laval Faculty of Medicine, and was greatly esteemed by those members of the English medical profession who had the pleasure of his acquaintance.

The degree of Doctor of Law has been conferred by the University of Michigan and Dickinson College upon Dr. Lewis Stephen Pilcher, of the Methodist Episcopal Hospital of Brooklyn, and editor of the *Annals of Surgery*.

Book Reviews.

Cancer of the Uterus. Its pathology and symptomatology diagnosis and treatment; also the pathology of diseases of the endometrium. By Thomas Stephen Cullen, M. B., Toronto; Associate Professor of Gynecology in the Johns Hopkins University. With eleven lithographic plates and over three hundred black and white illustrations on the text, by Max Brödel and Herman Becher. New York, D. Appleton & Company, 1900.

We cannot refrain from expressing our feelings of pride and gratification, which will, we believe, be shared by all Canadian physicians, when we look at this monumental monagraph of seven hundred pages, all on the subject of cancer of the uterus, and reflect that the most exhaustive work that has ever been written on this subject has been written by a Canadian. The scope of the work may best be judged from a portion of the preface, which we quote: "The number of cases of cancer of the genital tract coming too late for operation is so appalling that the surgeon is ever seeking to devise ways and means by which the dread malady may be more generally detected at the earliest possible moment—at a time when the complete removal of the malignant tissue is still possible. But since it is the general practitioner who as a rule in first consulted, upon him largely falls the responsibility of arriving at a timely diagnosis." In this volume it has been the author's aim to give the family physician a clear idea of the early signs of carcinoma, in order that he may always be on his guard and may not treat too lightly any suspicious indications which may be present. A perusal of the text reveals the high character of the

work. While we would wish most earnestly that the book might be widely read by all general practitioners, we fear that only a few of the most advanced ones will do so. Many of the chapters are devoted to the microscopical diagnosis, and will be eagerly studied by the specialists who are anxious to make an accurate diagnosis at the earliest possible moment after seeing the case. The work is therefore invaluable to the specialist, who cannot afford to be without it. The question as to what operation should be performed in a given case and the dangers and difficulties of each are thoroughly discussed. There are complete separate chapters on cancer of the cervix and cancer of the body of the uterus. The chapters on differential diagnosis are simply perfect. There is a special chapter on pregnancy complicated by cancer of the cervix, for which the author recommends hysterectomy by the abdomen. There are two excellent chapters on the etiology of the disease, the author leaning to the view that heredity seems to have very little influence; he says the weight of evidence is against the parasitic theory. But the best chapter of all is the appendix by Knowsley Thornton, of London, which should be read by every general practitioner, and from which we give a few extracts: "How is an early diagnosis to be made? Clearly by neglecting no menstrual departure from the normal, however trivial it might at first sight appear, but at once to encourage the patient to accurately describe symptoms, and, above all, to insist in the most determined manner on a local examination. Here it will be apparent that I, as a consultant, appeal for help to the great body of those who are now listening to my remarks, to my professional brethren engaged in general practice. I, in common with those situated as I am, too seldom have an opportunity of diagnosing early, because the majority of the patients come to us too late, when the disease has advanced nearly, or quite, beyond the limits of surgical aid. Let me, then, appeal to all engaged in family practice who listen to me here, and to that larger body who may read my words when reproduced in the medical journals, to sternly cast aside that too great modesty, or that tendency to treat as trivial, small symptoms, and to at once take alarm about, and carefully investigate every case in which there is brought to their notice an abnormality in menstruation or a vaginal discharge of any kind, however trifling. A very grave responsibility lies at the door of the medical profession for the small progress made in the early diagnosis of uterine cancer and its successful treatment. How constantly is the consultant told, 'I mentioned it to my doctor weeks or months ago, but he said, "Oh, it is nothing. I will send you a little medicine or a little injection," and never even suggested any internal examination, so I did not like to trouble him again till the pain became so bad or the discharge so troublesome, and then he examined me and said I must have special advice at once.'" Space prevents us from making other extracts, but the work is full of valuable advice, and should be in great demand. A. L. S.

Thompson's Practical Medicine.—A Text-Book of Practical Medicine By William Gilman Thompson, M.D., Professor of Medicine in Cornell University Medical College, New York City, Physician to the Presbyterian and

Bellevue Hospitals, New York. In one magnificent octavo volume of 1010 pages, with 79 engravings. Cloth, $5 net; leather, $6 net; half morocco, $6.50 net. Lea Brothers & Co., publishers.

Works on the Practice of Medicine have been of late years produced with great profusion, until one is almost at a loss to make a selection. This volume by Professor Thompson, of the Cornell University Faculty of Medicine, New York City, is so thorough and complete, that no one can make a mistake in putting it in a handy place in his library. Profesosr Thompson is a well-known worker, and the advent of a new century makes appropriate a comprehensive review of the present status of medical practice. It is the aim of this book to offer such a presentation. Special effort has been made to set forth clearly and simply those facts and principles which have received clinical proof, and to avoid those theories which have merely a speculative basis. The recent progress in pathology, clinical microscopy and bacteriology have greatly advanced the realm of definite knowledge, and corresponding modifications have taken place in previously existing views of the etiology, prevention and treatment of disease. The work is eminently practical, for the author has given his personal experience, which has extended over twenty years, and he writes with faith. He assumes that curative medicine is the avowed object for which medical men practice their art. He has therefore given especial care to the therapeutical sections, which are detailed and complete. A number of photo-gravures are introduced mostly from the author's collection, and very much enhance the value of the work. As a text-book for students, it must take a foremost place, and we confidently look for it being placed among the books recommended at all our Medical Schools. It is placed at a price within the reach of all, which indicates the confidence of its publishers in an unexampled sale. The type is particularly good, and reading does not tire the eyes.

F. W. C.

The Treatment of Fractures. By Charles Locke Scudder, M.D., Surgeon to the Massachusetts General Hospital, Out Patient Department; Assistant in Clinical and Operative Surgery in the Harvard Medical School; assisted by Frederic J. Cotton, M.D. With 585 illustrations. Philadelphia: W. B. Saunders, 925 Walnut Street, 1900. Canadian agents, J. A. Carveth & Co., Toronto, Ont. Price $4.50.

The volume here given us by Scudder, on a subject of such interest to not only the surgeon, but the general practitioner, is really one of unusual merit and well worthy of unlimited praise. It is especially interesting as fractures are of such frequent occurrence at all ages, and are liable to be followed by deformity or some permanent impairment of function, ending perhaps in litigation, that any work of such a practical nature as the one under review, whereby the diagnosis of these kinds of injuries may be simplified, must receive a warm and abiding welcome. The general use of anesthesia in the examination and the initial treatment of fractures,

especially of those near or involving joints, has made diagnosis more accurate and treatment more intelligent. The application of the Rontgen ray to the diagnosis of fracture of bone has already contributed much toward an accurate interpretation of the physical signs of fracture. The author says that this greater certainty in diagnosis has suggested more direct and simpler methods of treatment. Antisepsis has opened to operative surgery a very useful and profitable field in the treatment of fractures. The final results after the open incision of closed fractures emphasize the fact that anesthesia, antisepsis, and the Rontgen ray are making the know. ledge of fractures more exact, and their treatment less complicated.

This work is intended to serve as a guide to the practitioner and student. Many of the details in treatment of fractures are described, and as far as possible these details are illustrated. Mechanical simplicity is advocated. An exact knowledge of anatomy combined with accurate observation is recognized as the proper basis for the diagnosis and treatment of fractures. The expressions "closed" and "open" fracture are used in place of "simple" and "compound" fracture. "Closed" and "open" express definite conditions, referring to the freedom from, or liability to bacterial infection. The old expressions are misleading despite their long usage.

This work clearly explains the latest and best methods whereby we may correctly diagnose fractures, and then in an easy manner shows us the proper treatment to be used. One chapter deals with the uses of plaster-of-Paris and another takes up the ambulatory treatment of fractures. The volume is essentially practical, and should be in the possession of every practitioner who is desirous of obtaining a good practical grasp of the subject of the diagnosis and treatment of fractures. The work is more than well supplied with illustrations which are of unusual merit. We have no hesitation, after a close perusal, in recommending the book, which will prove of particular use to the general practitioner.

R. C.

A Text-Book of Practical Therapeutics. By Hobart A. Hare, M.D., B.Sc. Eighth edition, revised and largely re-written. Lea Bros. & Co., Philadelphia and New York, April, 1900.

This eighth edition in less than ten years proves the truth of the aphorism that "nothing succeeds like success." The secret of Prof. Hare's success in the volume before me lies in the fact that he knows the busy practitioner needs but a hint to place him on the right track, while the overburdened student cries aloud to be delivered from lengthy and erudite discussions of minute physiological actions, and appreciates something he can easily remember and make good use of in his prospective practice. In the nearly eight hundred pages of reading matter, there is not a redundancy of expression nor a word too much. Neither is there the jerky dogmatism that marks the quiz compend. The work is invaluable to the world of readers to whom it appeals, and will, I hope, see many revisions and editions at the hands of its capable author.

To those who, like the author, are teaching the subject, there will be, of course, always minor differences. Among them, the perennial question of classification. Personally I incline to Schmiedeberg, —while admitting that Hare's is handiest in a rush.

The illustrations are good and the colored plates excellent; the letter press is above reproach, and the paper, luckily, unglazed. Next to Bruton's Lectures, it is a book that should be on every practitioner's desk. R. W.

Atlas and Epitome of Special Pathologic History. By Docent Dr. Hermann Dürck, Assistant in the Pathologic Institute, Prosector to the Municipal Hospital, Munich. Authorized Translation from the German. Edited by Ludwig Hektoen, M.D., Professor of Pathology in Rush Medical College, Chicago. Circulatory Organs, Respiratory Organs, Gastro-Intestinal Tract. With 62 colored plates. W.B. Saunders, 925 Walnut Street, Philadelphia. 1900. Canadian Agents, J. A. Carveth & Co., Toronto, Ont. Price, $3.00 net.

We take pleasure in calling attention to this excellent translation of Dr. Dürck's Atlas and Epitome. Bearing in mind how difficult it is to correctly represent pathological appearances in colored plates, we have no hesitation in stating that the illustrations are, with few exceptions, faithful and typical pictures of the various pathological processes described. They are not the idealised and almost schematic representations of tissue changes such as adorn certain text-books of pathological histology. The plates on arteriosclerosis and arteritis, on adipositas cordis, on the pneumonias, are worthy of special notice. The work is well up to the standard of excellence of the Saunders' Hand Atlases, and is calculated to stimulate the student of pathology to personal observations of morbid histology. A. B.

A Manual of Obstetrics. By A. F. A. King, A. M., M. D., Prof. of Obstetrics and Diseases of Women and Children in the Medical Department of the Columbian University, Washington, D. C., and in the University of Vermont; President (1885-86-87) of the Washington Obstetrical and Gynæcological Society; President (1883) of the Medical Society of D. C.; Fellow of the British Gynæcological and of the American Gynæcological Societies; Consulting Physician to the Children's Hospital, Washington, D. C.; Obstetrician to the Columbian University Hospital; Member of the Washington Academy of Science; of the American Association for the Advancement of Science; Associate-Member of the Philosophical Society of Great Britain; and Member of the Medical Philosophical, Anthropological and Biological Societies of Washington, D.C., etc. Eighth Edition, revised and enlarged. 264 illustrations. Lea Brothers & Co., Philadelphia and New York, 1900.

The value of King's Manual of Obstetrics is perhaps best emphasized by the fact that since the first edition appeared in 1882, there have been no less than eight editions printed. It must have filled a want amongst students, or it most certainly would not have become so popular. Students have not the time to read systematic treatises, but need the facts stated as briefly and comprehensively as possible. The manner in which Dr. King italicizes the words that are important to convey the exact ideas he is trying to impress is certainly to be commended. It is up-to-date in theory, and

is correct, we think, when remedies are to be used, in not simply mentioning them by name, as so many works do, and which is proper for larger works, but the actual combination in the form of prescription. This, we believe, is much better for students. Whether for student or busy practitioner, we can most heartily recommend the work, whether for the initial study of the work or for refreshing the memory. For its small cost it should be found on every student's and practitioner's table. H. L. R.

A Practical Treatise on Sexual Disorders of the Male and Female. By Robt. W. Taylor, M. D. Lea Brothers & Co., New York and Philadelphia, 1900.

This work is eminently a practical one, and not a compilation as so many are at present. It is evidently written largely from the author's own experience and not overburdened, and is just what the general practitioner requires. J. P.

PUBLISHERS DEPARTMENT.

KEEP TAB ON TIME.—Believing thoroughly that "a thing of beauty is a joy for ever," and that an article of beauty and utility combined is worthy of preservation, The New York Pharmacal Association has prepared for distribution to the medical profession a handsome and artistic *perpetual* calendar, which is now ready for mailing. Instead of presenting a calendar at the beginning of the year, according to the usual custom, the above company prefers the season when the physician is not deluged with all sorts and conditions of chronological recorders, and is thus better enabled to welcome and appreciate such an addition to his office. The new Lactopeptine Perpetual Calendar is not intended for hanging upon the wall, but to stand upon the doctor's desk, and for this reason has a strong easel back to support it. The coloring is exceedingly soft and attractive, consisting of delicate shades of lavender, purple, crushed strawberry and buff yellow. The few words relative to Lactopeptine are entirely unobtrusive, and do not interfere in the least with the general artistic effect. In the near foreground on either side are two gracefully draped female figures with flowing hair; around the edges appear the various signs of the Zodiac.

One of these calendars will be sent to any physician who may request same.

SANMETTO IN PROSTATITIS AND CYSTITIS.—Dr. F. R. Dobson, of New Orleans, La., late Surgeon U.S.A., writing, says: "While Surgeon in First Division Hospital, stationed at Jacksonville, Fla., I had occasion to see an interesting case of prostatitis treated with Sanmetto, with entire success. The patient was a private in the Second Nebraska Vol., and his condition upon entering the hospital was deplorable, the bladder being distended with urine, the overflow dribbling constantly. His condition was traceable to gonorrheal infection. Since my return to New Orleans I treated with Sanmetto a case of purulent cystitis, which had resisted all other treatment. The result of the taking of one bottle of Sanmetto was permanent relief."

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